IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-971

STATE OF NORTH CAROLINA EX. REL. SARAH T. MORROW; STATE OF NEBRASKA; AMERICAN MEDICAL ASSOCIATION; and NORTH CAROLINA MEDICAL SOCIETY, *Appellants*,

v.

JOSEPH A. CALIFANO, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE; AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC.; and NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS, *Appellees*.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

JURISDICTIONAL STATEMENT

RUFUS L. EDMISTEN
Attorney General of The State of North Carolina
WILLIAM F. O'CONNELL
Special Deputy Attorney General
ROBERT R. REILLY
Assistant Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, North Carolina 27602
Attorneys for The State of North Carolina Appellant

PAUL L. DOUGLAS
Attorney General of The State of Nebraska
MELVIN KENT KAMMERLOHR
Assistant Attorney General of The State of Nebraska
2115 State Capitol
Lincoln, Nebraska 68509
Attorneys for The State of Nebraska Appellant

JOHN H. ANDERSON
HENRY A. MITCHELL
Smith, Anderson, Blount & Mitchell
First Union National Bank Building
Suite 500
Raleigh, North Carolina 27602
NEWTON N. MINOW
HOWARD J. TRIENENS
ROBERT D. MCLEAN
JACK R. BIERIG
WILLIAM F. LLOYD
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
Attorneys for the American Medical Association and North Carolina Medical Society Appellants

Of Counsel:
BERNARD D. HIRSH
B. J. ANDERSON
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

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Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

JURISDICTIONAL STATEMENT

Appellants seek review of the decision of the United States District Court for the Eastern District of North Carolina, entered on September 22, 1977, granting the motion of appellee Joseph A. Califano for summary judgment and dismissing appellants' complaint. That complaint alleges that the National Health Planning and Resources Development Act of 1974 (42 U.S.C. §300k *et seq.*) is unconstitutional and seeks a permanent injunction against the enforcement of that act.

OPINION BELOW

The opinion and order of the United States District Court for the Eastern District of North Carolina dated September 22, 1977, which is unreported, is annexed hereto as Appendix A.

JURISDICTION

The State of North Carolina instituted this action for injunctive and declaratory relief pursuant to 28 U.S.C. §§1331, 2201, and 2202. The action challenges the constitutionality of the National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat. 2226, 42 U.S.C. §300k *et seq.* The State of Nebraska, the American Medical Association, and the North Carolina Medical Society subsequently intervened pursuant to Rule 24(b) of the Federal Rules of Civil Procedure.

A three-judge district court was convened below pursuant to 28 U.S.C. §2282.[1] On September 22, 1977, the District Court entered final judgment adverse to appellants, and notice of appeal was filed in that court on November 9, 1977. A copy of the notice of appeal is annexed hereto as Appendix B.

Jurisdiction to review by direct appeal the order of the District Court is conferred by 28 U.S.C. §1253.

QUESTIONS PRESENTED

(1) Whether an Act of Congress requiring a state to enact legislation admittedly repugnant to that state's constitution, under penalty of forfeiture of all benefits under

[1]Section 2282 was repealed by Pub. L. 94-381, §2, 90 Stat. 1119, but the repeal was not applicable to any action commenced on or before August 12, 1976. This action was filed on April 27, 1976.

approximately fifty long-standing health care programs essential to the welfare of the state's citizens, violates the Tenth Amendment and fundamental principles of federalism.

(2) Whether use of the Congressional spending power to coerce states into enacting legislation and surrendering control over their public health agencies is inconsistent with the guarantee to every state of a republican form of government set forth in Article IV, §4 of the Constitution and with fundamental principles of federalism.

STATUTES INVOLVED

The National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat 2226, 42 U.S.C. §300k *et seq.*, is set forth in Appendix C to this Statement.

STATEMENT

This case presents issues of enormous public significance which were explicitly left unresolved in *National League of Cities* v. *Usery*, 426 U.S. 833, 852 n.17 (1976). It also presents related issues bearing directly on the role of the States in our federal system of government with respect to which the Court has previously granted plenary review. *See Brown* v. *Environmental Protection Agency*, 521 F.2d 827 (9th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977).

Appellants, including the State of North Carolina and the State of Nebraska, challenge the constitutionality of the National Health Planning and Resources Development Act of 1974 ("the Act" or "the Health Planning Act"). The Act provides for unprecedented federal government intrusion into, and control over, state legislative and administrative functions in the field of public health. In particular, the Act

requires Appellant North Carolina to amend its constitution, upon penalty of forfeiting all federal funding for approximately fifty public health programs which are critical to the health and welfare of its citizens and which have existed for many years prior to enactment of the Health Planning Act.

The Health Planning Act requires each state to establish a State Health Planning and Development Agency, or "State Agency," which must be designated by the state as the sole state agency with overall responsibility for and legally enforceable control over the planning and development of health care resources—regardless of the roles previously played by pre-existing state regulatory mechanisms. 42 U.S.C. §300m-1(b)(1). The State Agency must implement state health plans under the Act, under §1122 of the Social Security Act, 42 U.S.C. §1320a-1, and under pre-existing and prospective state law. 42 U.S.C. §300m-2(a). It is also required to approve all contracts and grants for the planning and development of health resources on the basis of approved priorities, to review no less than every five years all institutional health services being offered in the state, and to establish a state medical facilities plan. 42 U.S.C. §§300m–300m-2, 300o-2.

Most significantly, each state must adopt a certificate of need statute, satisfactory to the Secretary of Health, Education, and Welfare, under which no health care service, facility, or organization, whether public or private, may be built, equipped, expanded, or modernized without a certificate of need, 42 U.S.C. §300m-2(a)(4)(B). Under this drastic, unprecedented provision, a clinic or hospital which receives *no governmental aid whatsoever* can neither expand nor modernize its facilities unless it receives a certificate of need from a regulatory agency created pursuant to the Act. *Id.* A local community or even a group of private citizens which decides

that a particular medical facility is essential and which is willing to use solely private funds to construct that facility cannot do so unless the agency established pursuant to the Act decides that such a facility is needed. The Supreme Court of North Carolina has unanimously held that legislation establishing such a certificate of need system violates the Constitution of North Carolina. *In re Certificate of Need for Aston Park Hospital, Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973).

At the heart of the Act are the sanctions imposed if a state fails to comply with any of the requirements of the Act. Not only is a non-complying state denied funding under the Act, but in addition, under 42 U.S.C. §300m(d), neither the state nor any agency or resident thereof can receive any allotment, grant, loan, or loan guarantee or enter into any contract under three previously enacted statutes, the Public Health Service Act, 42 U.S.C. §201 *et seq.*, the Community Mental Health Centers Act, 42 U.S.C. §2681 *et seq.*, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 U.S.C. §4541 *et seq.*, encompassing at least fifty long-standing programs essential to the health of the state's citizens. Appendix D contains a partial listing of some such programs of particular importance to appellants.

None of these programs are created by the Health Planning Act. To the contrary, they have existed for many years, have been jointly funded by state and federal monies, and bear no direct relationship to the Health Planning Act. Nevertheless, that Act requires a state to enact certain legislation or lose all federal funding for all such programs, including funding for venereal disease prevention and control; student loans; diagnosis, treatment, and control of sickle cell anemia; family planning programs; family health service clinics for domestic agricultural migrants; and treatment,

training, and research in the field of mental health. The estimated annual monetary loss (in 1975 dollars) to Appellant State of North Carolina will be nearly fifty million dollars; that to Appellant State of Nebraska will be over seventeen million dollars. The human costs are incalculable.

Economic coercion of this magnitude by Congress is virtually irresistible, and most states will be constrained to surrender their sovereignty and enact the legislation dictated by Congress. Appellant North Carolina faces a constitutional dilemma of even greater proportions because the legislation required by Congress violates the Constitution of North Carolina. North Carolina must therefore amend its constitution or forfeit all such funding. Appellants ask the Court to review and reverse the decision of the United States District Court for the Eastern District of North Carolina upholding such unprecedented use of the Congressional spending power to strip states of their sovereignty.

THE QUESTIONS ARE SUBSTANTIAL

1. The Spending Power Is Not So Broad That The Federal Government May Coerce States Into Enacting Legislation Against Their Will And Surrendering Their Control Over Essential Governmental Functions.

This case raises the issue which was explicitly left unresolved by the Court in *National League of Cities* v. *Usery*, 426 U.S. 833, 852 n.17 (1976): Whether there are limits on the extent to which Congress may use its spending power granted by Art. I, §8 of the United States Constitution to accomplish indirectly a result which it cannot attain directly under the Commerce Clause and which is contrary to the Tenth Amendment and fundamental principles of federalism.

National League of Cities, supra, clearly indicates that Congress cannot under the Commerce Clause directly order

a state to enact legislation, in matters of traditional local governmental concern, which is contrary to the sovereign will of the state. Nor can there be any question that Congress may not utilize the Commerce Clause to require a state to amend its constitution. In the Health Planning Act, Congress has sought to accomplish the same result indirectly, by tying the continuation of funding under essential pre-existing programs to the enactment of specified state legislation. If such Congressional action is constitutionally permissible, then the principles of federalism underpinning *National League of Cities* will have little continuing vitality, for Congress will be able to intrude upon state sovereignty to whatever extent it desires simply by terminating or threatening to terminate critical federal funding to a state unless the state yields to Congressional commands. Appellants respectfully submit, therefore, that it is now essential for the Court to resolve the issue left open in *National League of Cities*, and define the limits upon use of the spending power to wrest from states control over those functions which are essential to their separate and independent existence as coordinate elements in our federal system.

Appellants recognize that Congress may utilize its spending power to induce states to cooperate on matters of national concern. The spending power is not, however, limitless. In order to define the permissible scope of the power, courts must assess whether the challenged Congressional action coerces the states or merely induces them to act, *see, e.g., Steward Machine Co.* v. *Davis*, 301 U.S. 548 (1937); *Vermont* v. *Brinegar*, 379 F. Supp. 606, 616 (D. Vt. 1974); the relationship, if any, between the challenged Congressional action and the federal spending that is threatened to be terminated as well as the ability of the states themselves to regulate the matter sought to be regulated by Congress, *see Steward Machine Co.* v. *Davis, supra; Vermont* v. *Brinegar, supra*; and whether Congress could accomplish its regulatory

aim by means of a less drastic interference with state sovereignty, *see National League of Cities, supra*, at 853. *See also* discussion of the scope of the commerce power in *District of Columbia* v. *Train*, 521 F.2d 971, 994 (D.C. Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977).

Under this analysis, the Health Planning Act fails to pass Constitutional muster. First, the Act's threatened withdrawal of benefits under pre-existing health care programs so drastically impairs the ability of the states to continue to perform one of their most important governmental functions, protection of the public health, that it constitutes coercion rather than inducement. A state has no practical alternative but to yield to the dictates of Congress because withdrawal of such funding would result in the breakdown of the entire health care system of the state. Neither North Carolina nor Nebraska can expose its citizens to such drastic sanctions. If such a threat of a complete curtailment of federal funding under approximately fifty pre-existing federal health care programs does not constitute an invalid penalty rather than a permissible inducement, as the District Court held, then clearly nothing short of complete termination of all federal funds whatsoever would constitute coercion. Such a limitation would, in effect, be no limitation whatsoever on the power of Congress to dictate to the states on virtually any subject, and would undercut completely the rule of *National League of Cities*. *See also Oregon* v. *Mitchell*, 400 U.S. 112, 126 (1970).

Second, the public health traditionally has been recognized as an area of particular state and local concern which individual states are fully capable of regulating.[2] Indeed, the

[2] *See National League of Cities* v. *Usery*, 426 U.S. 833, 851 (1976); *Barsky* v. *Board of Regents*, 347 U.S. 442, 449 (1954); and *Linder* v. *United States*, 268 U.S. 5, 17 (1925).

states are better suited to assess the particular needs of their citizens and the resources of their health care institutions.

Third, the penalty prescribed by the Health Planning Act bears little if any relationship to the regulatory objectives of the Act. The Act does not threaten to withhold new federal funding. Nor does it threaten to terminate only funding for health planning activities. Instead, it requires forfeiture of all federal funding for fifty unrelated and previously existing programs. Moreover, the Act seeks to regulate programs and activities which receive no federal funds whatsoever. It is one thing for Congress to condition the grant of a federal benefit on reasonable, narrow terms governing the use and provision of such benefit. It is quite another thing for Congress to arrogate to the federal government matters of traditional local control by threatening to terminate unrelated benefits which have been granted to, and relied upon by, the states for many years.[3]

Finally, there are less drastic methods of dealing with health cost control than requiring a state to amend its consti-

[3] In the context of federal regulation of academic institutions, Kingman Brewster, Jr. has said:

> "It is not sufficient to say that since the government is paying the bills, therefore it has a right to specify the product. This would be understandable if all that is being offered were special support for the program of special federal interest. To say, however, that support for all general educational activities of national importance will be withheld unless a school enlarges the program the government is particularly interested in, is to use the threat of cutting off aid for one purpose in order to accomplish another."

[Address to the Fellows of the American Bar Foundation, reprinted in *Yale Medicine*, Vol. 10 (Spring 1975) at 4.]. This observation is even more forceful when the object of federal regulation is not a private organization but a coordinate, sovereign element of our system of government.

tution and transform health care into a federally regulated public utility.[4] The court below did not consider obviously less drastic[4] alternatives because that court erroneously regarded the Congressional spending power as limitless.

2. The Guaranty Clause Forbids Federal Usurpation Of State Government Functions.

The Health Planning Act also contravenes the Guaranty Clause of Article IV, §4 in three respects. First, by requiring enactment by states of specified legislation and by granting to the federal government authority to approve or disapprove of the allocation of state resources to the State Agencies, it separates the spending power of the states from their taxing power and actually deprives the citizens of North Carolina and Nebraska of a substantial measure of control over the amount and manner of state expenditures. The Court has previously announced its intention to review this important issue, but the cases in question were instead vacated as moot following withdrawal of the federal regulatory action at issue. *Brown* v. *Environmental Protection Agency*, 521 F.2d 827, 840 (9th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977); *Maryland* v. *Environmental Protection Agency*, 530 F.2d 215 (4th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977).

Second, by coercing states to enact legislation and allocate resources against their will, the Act deprives citizens of such states of their self-determination. This problem is most dramatically illustrated by the dilemma in which North Carolina finds itself: Under the Act, it must either suffer the

[4] *See, e.g.*, Section 1122 of the Social Security Act, 42 U.S.C. §1320a-1, which pertains only to the provision of federal monies and does not regulate private medical activities.

collapse of its public health system for lack of federal funding or it must amend its constitution.

Third, the Health Planning Act subverts the independence of state government by effectively transforming state officials into agents of the federal government whose every action is controlled by federal administrators. The Act subjects state agencies to pervasive federal controls not only when the agencies administer federal programs but in every aspect of public health planning, regardless of the relationship of that planning to any federal concern or activity. Under the Act, any state agency which conducts health planning activities is subject to complete federal control. 42 U.S.C. §§300m-2(a)(1), 300m-1(b)(1) and 300m-1(b)(4–6).

The court below gave scant consideration to these arguments and essentially relied on the erroneously oversimplified view that since the federal government is providing funding, the federal government is entitled to determine the manner in which the funds are dispensed. Appendix A at a-5. There are at least three conspicuous flaws in this analysis. In the first place, as discussed *supra* at 4–5, the Health Planning Act seeks to extend federal control to all health care facilities regardless of whether they receive any federal funding. Second, even when federal funding is at issue, it is not merely the federal government that provides the funds. The projects are joint with states such as North Carolina and Nebraska, expending state monies as well. Finally, the penalty provided by the Act pertains to preexisting programs for which funds have already been spent and with respect to which a state does not have the same ability to refuse to participate as would be the case if the programs had never been initiated. Appellants respectfully submit that there must be some limit on the ability of Congress to fund programs jointly with the states, to induce reliance of the citizenry, particu-

larly the old and the infirm, on such programs and then to use the threat of termination of such programs to seize effective control of taxing and spending powers of states which are otherwise protected by the Guaranty Clause.

> As the Court noted in *In re Duncan*, 139 U.S. 449 (1891):
>
> "By the Constitution, a republican form of government is guaranteed to every State in the Union, and the distinguishing feature of that form is the right of the people to choose their own officers for governmental administration, and pass their own laws in virtue of the legislative power reposed in representative bodies, whose legitimate acts may be said to be those of the people themselves . . . ." *Id.* at 461.

The Health Planning Act reduces that right to an empty formality by requiring states to enact legislation prescribed by the federal government and to cede to the Secretary control over the budgets and performance of state health care agencies. It has been recognized in recent years, however, that the Guaranty Clause, like the Tenth Amendment, is not a mere formality but instead an important safeguard of rights within a federal system and that the clause is judicially enforceable. See *Kohler* v. *Tugwell*, 292 F. Supp. 978, 984–5 (E.D. La. 1968) (Three-Judge Court), *aff'd*, 393 U.S. 531 (1969). Thus, the Court should hold the Health Planning Act invalid as repugnant to the Guaranty Clause.

CONCLUSION

As Mr. Justice Rehnquist noted in *Fry* v. *United States*, 421 U.S. 542, 559 (1975):

> "Surely there can be no more fundamental constitutional question than that of the intention of the Framers of the Constitution as to how authority should be allocated between the National and State Governments."

Moreover, the questions presented by this case transcend even principles of federalism, for the permissible scope of the spending power affects not only powers reserved to the states but also rights of individual citizens.

Appellants, who include two states of the United States, have raised a fundamental constitutional question—a question explicitly left open by the Court only two years ago. The decision below dealt with this important question in an extremely abbreviated fashion, and appellants respectfully suggest that summarily to affirm that decision could well inhibit the careful and orderly development of extraordinarily significant constitutional principles.[5]

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[5] *See Colorado Springs Amusements, Ltd.* v. *Rizzo*, 428 U.S. 913 (Opinion of Mr. Justice Brennan). *See generally* Note, *Summary Disposition of Supreme Court Appeals*, 52 B.U. L. Rev. 373 (1972).

The scope of the Spending Power is perhaps the most important constitutional subject of this generation. Appellants respectfully submit that issues of this magnitude require plenary review.

Respectfully submitted,

RUFUS L. EDMISTEN
Attorney General of
The State of North Carolina

WILLIAM F. O'CONNELL
Special Deputy Attorney General

ROBERT R. REILLY
Assistant Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, North Carolina 27602
Attorneys for
The State of North Carolina
Appellant

PAUL L. DOUGLAS
Attorney General of
The State of Nebraska

MELVIN KENT KAMMERLOHR
Assistant Attorney General of
The State of Nebraska
2115 State Capitol
Lincoln, Nebraska 68509
Attorneys for
The State of Nebraska
Appellant

JOHN H. ANDERSON
HENRY A. MITCHELL
Smith, Anderson, Blount & Mitchell
First Union National Bank Building
Suite 500
Raleigh, North Carolina 27602

NEWTON N. MINOW
HOWARD J. TRIENENS
ROBERT D. MCLEAN
JACK R. BIERIG
WILLIAM F. LLOYD
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
Attorneys for the American Medical Association and North Carolina Medical Society
Appellants

Of Counsel:
BERNARD D. HIRSH
B. J. ANDERSON
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
RALEIGH DIVISION

No. 76-0049-Civ-5

STATE OF NORTH CAROLINA EX REL SARAH T. MORROW, Secretary of the North Carolina Department of Human Resources,
Plaintiff,
AMERICAN MEDICAL ASSOCIATION and NORTH CAROLINA MEDICAL SOCIETY,
Plaintiffs-Intervenors,
STATE OF NEBRASKA,
Plaintiff-Intervenor,
—VERSUS—
JOSEPH A. CALIFANO, Secretary of the United States Department of Health, Education and Welfare,
Defendant,
AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC.,
Defendant-Intervenor,
NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS,
Defendant-Intervenor.

(Filed September 22, 1977)

OPINION and ORDER

Heard: July 6, 1977 Decided: September 22, 1977

THREE-JUDGE COURT: RUSSELL, Circuit Judge, LARKINS, Chief District Judge, and DUPREE, District Judge.

This is a suit against the Secretary of Health, Education and Welfare challenging the constitutionality of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. 300k *et seq.* (hereinafter referred to as "the Act"). The original complainant was the State of North Carolina. Later, interventions by the American Medical Association, the North Carolina Medical Society, as well as by the State of Nebraska, were allowed.

The attack by North Carolina on the Act focuses primarily on the requirement thereunder that any State, in order to qualify for financial grants under the federal health programs, should establish a State Health Planning and Development Agency, which, among other things, should "administer a State certificate of need program [satisfactory to the Secretary] which applies to new institutional health services proposed to be offered or developed within the State" and under which "only those services, facilities, and organizations found to be needed shall be offered or developed in the State."[1] And the reason for the State's concern is found in the decision of its own Supreme Court that a certificate of need statute as required under the Act "is in excess of the constitutional power of the Legislature." *In Re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S. E. 2d 729, 733 (1973). Absent a constitutional amendment, the State argues it would be required by the challenged provision of the Act to forfeit its right to participate in some forty-odd federal financial assistance health programs. It contends that, under these circumstances, the requirement represents an effort to compel the State to amend its constitution and thus constitutes an unconstitutional interference with the State's legislative and constitutional processes violative of the principles of federalism and state sovereignty, as guaranteed under the due process clause, the Tenth Amendment and the Guaranty Clause of Article IV, Section 4 of the Constitution.

[1] 42 U.S.C. §300m-2(a)(4)(B).

The American and North Carolina Medical Associations, who have intervened in support of the plaintiff North Carolina, join in the grounds raised by North Carolina against the validity of the certificate of need requirement. In addition, they argue that the Act is invalid because it seeks to convert private facilities into public facilities subject to federal regulation and "interferes with the physician-patient relationship by rationing health resources for reasons unrelated to the promotion of high quality care." They rely, as authority for their special contentions, on the First, Fifth and Ninth Amendments.

The intervenor Nebraska, which similarly supports the position of North Carolina, also asserts an independent ground of attack on the Act. It would find invalid on constitutional grounds the population requirements for health service areas established under the Act and the related waiver provisions.

The defendant, in his answer, denies the validity of the contentions of the plaintiff and its supporting intervenors. As is obvious, there are no real issues of contested fact; the dispositive issues are legal. All parties have recognized this and both sides have moved for summary judgment. Under these circumstances, disposition of the cause on the basis of such motions is appropriate.

As we have said, the primary attack of the plaintiff North Carolina relates to the certificate of need requirement in the Act. In making such an attack, the plaintiff concedes

that, in the exercise of a valid spending power, the federal government may impose terms and conditions upon fiscal grants allotted by it among the States. *King v. Smith* (1968) 392 U. S. 309; *Oklahoma v. Civil Service Comm'n.* (1947) 330 U. S. 127. Nor does the plaintiff dispute the validity of federal appropriations to promote the public health under the general welfare clause. Its attack on the certificate of need requirement is that, while Congress may attach conditions to federal grants to the states, such conditions may not be arbitrary, may not be unrelated to the legitimate purposes of federal health legislation, and may not invade the sovereign rights of the states.

The Act as a whole had as one of its basic purposes the more efficient and economical uses of health services. It grew out of a Congressional concern that the many unneeded hospital beds available in the nation imposed an unnecessarily exorbitant financial burden on the furnishing of required health care, and that there was an uneven distribution of health care facilities, resulting in some areas being over supplied and others being woefully deficient.[2] It sought through a national health planning policy to provide for the development of a program for dealing with the "maldistribution of health care facilities and manpower" and to "authorize financial assistance for the development of resources to further that policy."[3] An integral part of such a program was the certificate of need requirement which the plaintiff assails. The State health planning and development agency, authorized under the Act, was to "[s]erve as the designated planning agency of the State [to] *** (B) administer a State certificate of need program which [should apply] to new institutional

[2] *See U.S. Code Congr. & Admn. News*, 93rd Cong., 2d Sess., 1974, pp. 7878-9.

[3] 42 U.S.C. 300k(a) (B) and (b).

health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed ***, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State."[4]

We perceive nothing unconstitutional either in the purposes of the Act or in the condition thereby attached to health grants made to the States under federal health programs. Without question Congress in making grants for health care to the States, should be vitally concerned with the efficient use of the funds it appropriated for that purpose. It had a perfect right to see that such funds did not cause unnecessary inflation in the cost of health costs to the individual patient. It certainly had the power to attach to its grants conditions designed to accomplish that end.

The plaintiff argues, however, that however valid such power may be generally, this power of the federal government to attach conditions to grants to the States is not an unlimited one and may not be stretched to validate "coercive" conditions; and that it urges is the necessary consequences of the requirement of a State certificate of need law. In support of this argument, it relies primarily on *Steward Machine Co. v. Davis* (1937) 301 U. S. 548. In *Steward*, the Court recognized that to hold "motive or temptation [on the part of a State to comply with a condition attached to a federal appropriation grant] is [to be construed as] equivalent to coercion is to plunge the law in endless difficulty."[5] It accordingly declared as a general rule, that whenever the condition attached by Congress to an appropriation

[4] 42 U.S.C. § 300m-2(a)(4)(A)(B).

[5] 301 U. S. at 589–590.

grant available to the States relates to a "legitimately national" purpose, inducement or temptation to conform[6] does not go beyond the bounds of the federal government's legitimate spending power and is not coercion in any constitutional sense.[7]

It is not to be assumed that the plaintiff would argue that fiscal support for a national health program is not a legitimate national interest, which will support a federal grant to the States. Were it to do so, it would undercut the very basis of its action, which seeks to secure the benefits of such grants without compliance with the challenged condition. Accepting then the premise that such federal support is constitutionally valid, it would seem manifest that the federal government could validly attach a condition which was intended to assure the efficient use of the funds so granted. Such a condition would certainly relate to the legitimate national interest in health. So viewed, it would satisfy the standard phrased by Justice Cardozo in *Steward* and would be no more onerous on States than countless other federal programs in other fields, such as highways, etc.

The plaintiff, North Carolina, would, however, find the condition coercive under the unique circumstances applicable to it. This situation arises because the Supreme Court of North Carolina, by declaring that the Constitution of North Carolina, as it presently exists, proscribes the creation and operation of a state certificate of need mechanism.[8] As a

[6]In our recent opinion in *State of Maryland v. Environmental Protection Ag.* (4th Cir. 1975) 530 F. 2d 215 at 229, *vacated and remanded* 429 U. S. 1036, we spoke of these inducements as "[t]he alternative whip of economic pressure and seductive favor," which are legitimate under the constitutional spending power.

[7]301 U. S. at 591.

[8]*In Re Certificate of Need for Aston Park Hosp., Inc., supra,* 282 N. C. 542, 193 S. E. 2d 729 (1973).

result of that ruling North Carolina is threatened with a future loss of federal aid under some forty-two federal health assistance programs, a loss which can only be avoided by a constitutional amendment. When a legislative condition operates that drastically upon a State, the plaintiff contends, it becomes "coercive," and not simply inducement. It is unfortunate that its Constitution, as presently phrased and interpreted, might prevent compliance by North Carolina with the federally established condition. Simply because one State, by some oddity of its Constitution may be prohibited from compliance is not sufficient ground, though, to invalidate a condition which is legitimately related to a national interest sought to be achieved by a federal appropriation and which does not operate adversely to the rights of the other States to comply. Were this not so, any State, dissatisfied by some valid federal condition on a federal grant could thwart the congressional purpose by the expedient of amending its Constitution or by securing a decision of its own Supreme Court. The validity of the power of the federal government under the Constitution to impose a condition on federal grants made under a proper Constitutional power does not exist at the mercy of the State Constitutions or decisions of State Courts. Moreover, the "coercive" effect of a termination of federal assistance on the plaintiff North Carolina seems quite unreal. The actual loss to North Carolina should it lose all federal assistance health grants would be less than fifty million dollars; in 1974, its State revenues totalled some 3.1 billion dollars. The impact of such loss could hardly be described as "catastrophic" or "coercive."

It must be remembered that this Act is not compulsory on the State. Unlike the legislation faulted in *State of Maryland v. Environmental Protection Ag., supra,* 530 F. 2d 215, it does not impose a mandatory requirement to enact legislation on the State; it gives to the states an *option* to enact such

legislation and, in order to induce that enactment, offers financial assistance.[9] Such legislation conforms to the pattern generally of federal grants to the states and is not "coercive" in the constitutional sense.

It is true that the assailed condition contemplates that the state certificate of need program will apply to all health facilities constructed or expanded in the State. It will therefore cover the construction of new, or the expansion of existing health facilities, whether publicly or *privately* owned and financed. It is obvious, though, that, if only public construction were covered by the certificate of need program, the public interest in avoiding unnecessary increases in health care by reason of the addition of unneeded additional facilities could be thwarted by private construction. For this reason, every court which has considered the constitutional validity of state certificate of need laws has found that the inclusion of private construction within the law's coverage valid and reasonable, save in the North Carolina case already cited. *See, Simon v. Cameron* (C.D.Cal. 1970) 337 F. Supp. 1380; *Attoman v. Department of Social Welfare* (1966) 270 N.Y.S. 2d 167, 27 A.D.2d 12; *Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty* (1974) (N.J. App.) 330 A. 2d 370. We find the reasoning of these cases sound, as applied to this Act.

We find equally unpersuasive that this Act, with its certificate of need condition, threatens "the integrity of a recognized state government" and the "Republican form of government" and is therefore violative of the Guaranty Clause of the Constitution, Article IV, Section 4, or the Tenth Amendment. As we have already observed, the statutory condition on which the plaintiff directs its attack is not

[9]*Massachusetts v. Mellon* (1923) 262 U. S. 447, 480.

mandatory but is to be adopted or not at the option of the State and its burden on the State, if it should operate to terminate the plaintiff's right to participate under the federal health assistance programs, would not be coercive.[10]

The Medical Associations would fault the Act as an unlawful invasion of the patient-doctor relationship. We have carefully reviewed the Act and we find no basis for such claim. It follows that the challenge of the plaintiff North Carolina and the intervenors Medical Associations to the Act fails.

It remains to consider the special attack of the intervenor Nebraska on that provision of the Act which directs that each health service area under the Act contain a population of at least 500,000, except in "unusual" or "highly unusual" circumstances, to be determined by the Secretary. It urges that such a classification has no rational relationship to "the stated priorities of said Act." The legislative history indicates that Congress concluded that any effective planning of health care required as a necessary operating predicate "an adequate base of population and health resources" and, to achieve such a "base" it arrived at the population stan-

[10]Plaintiff cites *National League of Cities v. Usery* (1976) U.S. , 44 U.S.L.W. 4974. That case is not in point. It involved whether the Commerce Clause authorized a wage-hour amendment covering the employees of states or their subdivisions. We do not have such a direct regulation here; neither is the constitutional basis for the condition the Commerce Clause. The constitutional authorization in this case is the "spending power." *See* Note, *Applying the Equal Pay Act to State and Local Governments: The Effect of National League of Cities v. Usery*, 125 *U. Pa. L. Rev.* 665 at 676. In *Usery*, the Court was careful to point out that it was not considering the validity of the federal legislation under that power. The limited application of *Usery* was recognized in *Usery v. Charleston County School District* (4th Cir. 1977) F. 2d .

dard stated in the Act. We are unable to say that such legislative determination was arbitrary or irrational. Neither do the exemptions or waivers allowable for "unusual" circumstances fall under any constitutional interdict. The Congress in so providing, recognized that there might be areas in the nation where some variation from the population pattern would be justified "to overcome travel time, geographic and/or economic barriers to receipt of health services in non-metropolitan areas." This would appear a reasonable provision.

Accordingly, the motion of the defendant for summary judgment is granted.

AND IT IS SO ORDERED.

/s/ DONALD RUSSELL
U. S. Circuit Judge

/s/ JOHN D. LARKINS, JR.
Chief U. S. District Judge

/s/ FRANKLIN T. DUPREE, JR.
U. S. District Judge

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
RALEIGH DIVISION

STATE OF NORTH CAROLINA EX REL SARAH T. MORROW, Secretary of the North Carolina Department of Human Resources, *Plaintiff*, AMERICAN MEDICAL ASSOCIATION and NORTH CAROLINA MEDICAL SOCIETY, *Plaintiff-Intervenors*, STATE OF NEBRASKA, *Plaintiff-Intervenor*, —VERSUS— JOSEPH A. CALIFANO, Secretary of the United States Department of Health, Education and Welfare, *Defendant*, AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC., *Defendant-Intervenor*, NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS, *Defendant-Intervenor*.	CIVIL ACTION NO. 76-0049-CIV-5

(Filed November 9, 1977)

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that the plaintiff State of North Carolina ex rel Sarah T. Morrow and plaintiff-intervenors

American Medical Association, North Carolina Medical Society and the State of Nebraska hereby appeal to the Supreme Court of the United States from the final judgment allowing the motion of the defendant for summary judgment and dismissing the action herein on September 30, 1977.

This appeal is taken pursuant to 28 U.S.C. 1253.

Respectfully submitted,

For the State of North Carolina:

/s/ WILLIAM F. O'CONNELL

Rufus L. Edmisten, *Attorney General*

William F. O'Connell, *Special Deputy Attorney General*

Robert R. Reilly, *Assistant Attorney General*

NORTH CAROLINA DEPARTMENT OF JUSTICE
P.O. Box 629
Raleigh, North Carolina 27602
(919) 733-4618

For the American Medical Association and North Carolina Medical Society:

/s/ JOHN H. ANDERSON

John H. Anderson

Henry A. Mitchell

SMITH, ANDERSON, BLOUNT & MITCHELL
First Union National Bank Building
Suite 500
Raleigh, North Carolina 27602
(919) 821-1220

Newton N. Minow

Jack R. Bierig

SIDLEY & AUSTIN
One First National Plaza
Chicago, Illinois 60603
(312) 329-5400

For the State of Nebraska:

/s/ MEL KAMMERLOHR

Mel Kammerlohr
Assistant Attorney General
2115 State Capitol
Lincoln, Nebraska 68509

Date: 9th November, 1977

PROOF OF SERVICE

I, William F. O'Connell, attorney for plaintiff State of North Carolina ex rel Sarah T. Morrow, appellant herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that, on the 9th day of November, 1977, I served copies of the foregoing Notice of Appeal to the Supreme Court of the United States on the parties required to be served by placing said documents in envelopes with first class postage affixed and by depositing said envelopes in the United States Post Office in Raleigh, North Carolina, said envelopes being addressed as follows:

Solicitor General
Department of Justice
Washington, D.C. 20530

Rex E. Lee
Assistant Attorney General
Department of Justice
Tenth and Constitution Avenue
Washington, D.C. 20530

Carl Tilghman
U.S. Attorney
Box 26897
Post Office Building
Raleigh, North Carolina 27611

William H. Taft, IV
General Counsel
Department of Health, Education and Welfare
Washington, D.C. 20201

Richard G. Vernon
William G. Kopat
1900 M Street, N.W.
Suite 730
Washington, D.C. 20036

Eugene Hafer
1618 Glenwood Avenue
P.O. Box 6434
Raleigh, North Carolina 27608

Adam Stein
Chambers, Stein, Ferguson, & Becton
P.O. Box 720
Chapel Hill, North Carolina 27514

Joseph N. Onek
Herbert Semmel
Center for Law and Social Policy
1751 "N" Street, N.W.
Washington, D.C. 20036

All parties required to be served have been served.

/s/ William F. O'Connell

William F. O'Connell
Special Deputy Attorney General
North Carolina Dept. of Justice
P.O. Box 629
Raleigh, North Carolina 27602
(919) 733-4618

APPENDIX C

The National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat. 226, 42 U.S.C. §300k *et seq.* provides in pertinent part as follows:

§300k. *Congressional findings*

(a) The Congress makes the following findings:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services.

(b) In recognition of the magnitude of the problems described in subsection (a) of this section and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

§300k-1. *Regulations prescribing guidelines*

(a) The Secretary shall, within eighteen months after January 4, 1975, by regulation issue guidelines concerning national health planning policy and shall, as he deems appropriate, by regulation revise such guidelines. Regulations under this subsection shall be promulgated in accordance with section 553 of Title 5.

(b) The Secretary shall include in the guidelines issued under subsection (a) of this section the following:

(1) Standards respecting the appropriate supply, distribution, and organization of health resources.

(2) A statement of national health planning goals developed after consideration of the priorities, set forth in section 300k–2 of this title, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

(c) In issuing guidelines under subsection (a) of this section the Secretary shall consult with and solicit recommendations and comments from the health systems agencies designated under part B of this subchapter, the State health planning and development agencies designated under part C of this subchapter, the Statewide Health Coordinating Councils established under part C of this subchapter, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 300k–3 of this title.

§300k–2. *National health priorities*

The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(4) The training and increased utilization of physician assistants, especially nurse clinicians.

(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act.

(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

§300*l*. *Health service areas*

(a) There shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 300*l*–4 of this title. Each health service area shall meet the following requirements:

(1) The area shall be a geographic region appropriate for the effective planning and development of health services determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

(2) To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.

(3) The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that—

(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

(B) the population of an area may—

(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

(ii) be less than—

(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary),

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

(4) To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1320c–1 of this title for Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas.

The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other

requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.

(b)(1) Within thirty days following January 4, 1975, the Secretary shall simultaneously give to the Governor of each State written notice of the initiation of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

(A) A statement of the requirement (in subsection (a) of this section) of the establishment of health service areas throughout the United States.

(B) A statement of the criteria prescribed by subsection (a) of this section for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty days of January 4, 1975, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

(2) Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 246(a) of this title, each entity within the State which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 246(b) of this title, and each regional medical program established in the State under subchapter VII of this chapter.

(3)(A) Within two hundred and ten days after January 4, 1975, the Secretary shall publish as a notice in the Federal Register the health service area boundary designations. The boundaries for health service areas submitted by the Governors shall, except as otherwise provided in subparagraph (B), constitute upon their publication in the Federal Register the boundaries for such health service areas.

(B)(i) If the Secretary determines that a boundary submitted to him for a health service area does not meet the requirements of subsection (a) of this section, he shall, after consultation with the Governor who submitted such boundary, make such revision in the boundary for such area (and as necessary, in the boundaries for adjoining health service areas) as may be necessary to meet such requirements and publish such revised boundary (or boundaries); and the revised boundary (or boundaries) shall upon publication in the Federal Register constitute the boundary (or boundaries) for such health service area (or areas). The Secretary shall notify the Governor of each State in which is located a health service area whose boundary is revised under this clause of the boundary revision and the reasons for such revision.

(ii) In the case of areas of the United States not included within the boundaries for health service areas submitted to the Secretary as requested under the notice under paragraph (1), the Secretary shall establish and publish in the Federal Register health service area boundaries which include such areas. The Secretary shall notify the Governor of each State in which is located a health service area the boundary for which is established under this clause of the boundaries established. In carrying out the requirement of this clause, the Secretary may make such revisions in boundaries submitted under subparagraph (A) as he determines are necessary to meet the requirement of subsection (a) of this section for the establishment of health service areas throughout the United States.

(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a) of this section, he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B of this subchapter and the appropriate Statewide Health Coordinating Council established under part C of this subchapter. A request for boundary revision shall be made only after consultation with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision.

(5) Within one year after January 4, 1975, the Secretary shall complete the procedures for the initial establishment of the boundaries of health service areas which (except as provided in section 300n–5 of this title) include the geographic area of all the States.

(c) Notwithstanding any other requirement of this section, an area—

(1) for which has been developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 246(b) of this title, and

(2) which otherwise meets the requirements of subsection (a) of this section,

shall be designated by the Secretary as a health service area unless the Governor of any State in which such area is located, upon a finding that another area is a more appropriate region for the effective planning and development of health resources, waives such requirement.

§300*l*–1. *Health systems agency*

(a) For purposes of this subchapter, the term "health systems agency" means an entity which is organized and operated in the manner described in sub-

section (b) of this section and which is capable, as determined by the Secretary, of performing each of the functions described in section 300*l*–2 of this title. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) of this section and section 300*l*–2 of this title.

(b)(1) A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before January 4, 1975) to carry out health planning and review functions such as those described in section 300*l*–2 of this title, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

(2) Staff.

(A) A health systems agency shall have a staff which provides the agency with expertise in at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii) health planning, and (iv) development and use of health resources. The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function.

(B) The size of the professional staff of any health systems agency shall be not less than five, except that if the quotient of the population (rounded to the next highest one hundred thousand) of the health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff shall be the lesser of (i) such quotient, or (ii) twenty-five. The members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities. If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. Compensation for consultants and for contracted services shall be established in accordance with standards established by regulation by the Secretary.

(3) Governing body.

(A) A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with subparagraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in section 300*l*–2 of this title.

Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an "executive committee") composed, in accordance with subparagraph (C), of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

(B) The governing body—

(i) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria (developed and published pursuant to section 300n–1 of this title) applicable to its functions under subsections (e), (f), and (g) of section 300*l*–2 of this title;

(ii) shall be responsible for the establishment of the health systems plan and annual implementation plan required by section 300*l*–2(b) of this title;

(iii) shall be responsible for the approval of grants and contracts made and entered into under section 300*l*–2(c)(3) of this title;

(iv) shall be responsible for the approval of all actions taken pursuant to subsections (e), (f), (g), and (h), of section 300*l*–2 of this title;

(v) shall (I) issue an annual report concerning the activities of the agency, (II) include in that report the health systems plan and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities, and (III) make the report readily available to the residents of the health service area and the various communications media serving such area;

(vi) shall reimburse its members for their reasonable costs incurred in attending meetings of the governing body;

(vii) shall meet at least once in each calendar quarter of a year and shall meet at least two additional times in a year unless its executive committee meets at least twice in that year; and

(viii) shall (I) conduct its business meetings in public, (II) give adequate notice to the public of such meetings, and (III) make its records and data available, upon request, to the public.

The governing body (and executive committee (if any)) of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is in attendance. A quorum for a governing body and executive committee shall be not less than one-half of its members.

(C) The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

(i) A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.

(ii) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, optometrists, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, substance abuse treatment facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 300n(3)) of this title.

(iii) The membership shall—

(I) Include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health,

(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 300e–9 of this title), include at least one member who is representative of such organizations.

(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph.

(4) No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this subchapter, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

(5) No health systems agency may accept any funds or contributions of services or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources unless, in the case of an entity, it is an organization described in section 509(a) of Title 26 and is not directly engaged in the provision of health care in the health service area of the agency. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees.

(6) Each health system agency shall—

(A) make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(B) provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this subchapter and section 300t of this title; and

(C) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records pertinent to the disposition of amounts received from the Secretary under this subchapter and section 300t of this title.

(c) A health systems agency may establish subarea advisory councils representing parts of the agencies' health service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of subsection (b)(3)(C) of this section.

§300*l*–2. *Functions of health systems agencies*

(a) For the purpose of—

(1) improving the health of residents of a health service area,

(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

(3) restraining increases in the cost of providing them health services, and

(4) preventing unnecessary duplication of health resources,

each health systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. To meet its primary responsibility, a health systems agency shall carry out the functions described in subsections (b) through (g) of this section.

(b) In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning—

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

(E) the patterns of utilization of the area's health resources, and

(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 242k(e) of this title.

(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 300k–1 of this title, the priorities set forth in section 300k–2 of this title, and the data developed pursuant to paragraph (1), establish, annually review, and amend as necessary a health systems plan (hereinafter in this subchapter referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; and (C) which take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 300k–1 of this title respecting supply, distribution, and organization of health resources and services. Before establishing an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP.

(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this subchapter referred to as the "AIP") which describes objectives which will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the cost of attaining such objectives to their benefits, and which are fitted to the special needs of the area.

(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

(2) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and

private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 300n–1(b) of this title.

(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entitles to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 300t of this title. No grants or contract under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program.

(d) Each health systems agency shall coordinate its activities with—

(1) each Professional Standards Review Organization (designated under section 1320c–1 of this title),

(2) entities referred to in paragraphs (1) and (2) of section 3334(a) of this title and regional and local entities the views of which are required to be considered under regulations prescribed under section 4233 of this title to carry out section 4231(b) of this title,

(3) other appropriate general or special purpose regional planning or administrative agencies, and

(4) any other appropriate entity,

in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

(i) appropriated under this chapter, the Community Mental Health Centers Act, sections 409 and 410 of the Drug Abuse Office and Treatment Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources; or

(ii) made available by the State in which the health service area is located (from an allotment to the State under an Act referred to in clause (i))

for grants or contracts for the development, expansion, or support of health resources.

(B) A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under subchapter III, V, or VI of this chapter unless the grants or contracts are to be made, entered into or used to support the development of health resources intended for use in the health service area or the delivery of health services. In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or inter-tribal Indian organization for any program or project which will be located within or will specifically serve—

(i) a federally-recognized Indian reservation,

(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian-owned land area, or

(iii) a Native village in Alaska (as defined in section 1602(c) of Title 43),

a health systems agency shall only review and comment on such proposed use.

(2) Notwithstanding any other provision of this chapter or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review required by such paragraph. If an agency disapproves a proposed use in its health service area of Federal funds described in paragraph (1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Secretary its comments on the decision. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.

(3) Each health systems agency shall provide each Indian tribe or intertribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of this subsection.

(f) To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 300m–2 (a) of this title each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency.

(g) (1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 300m of this title for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 300*l*–4(c) of this title.

(h) Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects.

§300*l*–3. *Assistance to entities desiring to be designated as health systems agencies*

The Secretary may provide all necessary technical and other non-financial assistance (including the preparation of prototype plans of organization and operation) to nonprofit private entities (including entities presently receiving financial assistance under section 246 (b) of this title or subchapter VII of this chapter or as experimental health service delivery systems under section 242b of this title) which—

(1) express a desire to be designated as health systems agencies, and

(2) the Secretary determines have a potential to meet the requirements of a health systems agency specified in sections 300*l*–1 and 300*l*–2 of this title,

to assist such entities in developing applications to be submitted to the Secretary under section 300*l*–4 of this title and otherwise in preparing to meet the requirements of this part for designation as a health systems agency.

§300*l*–4. *Designation of health systems agencies*

(a) At the earliest practicable date after the establishment under section 300*l* of this title of health service areas (but not later than eighteen months after January 4, 1975) the Secretary shall enter into agreements in accordance with this section for the designation of health systems agencies for such areas.

(b) (1) The Secretary may enter into agreements with entities under which the entities would be designated as the health systems agencies for health service areas on a conditional basis with a view to determining their ability to meet the requirements of section 300*l*–1(b) of this title, and their capacity to perform the functions prescribed by section 300*l*–2 of this title.

(2) During any period of conditional designation (which may not exceed 24 months), the Secretary may require that the entity conditionally designated meet only such of the requirements of section 300*l*–1(b) of this title and perform only such of the functions prescribed by section 300*l*–2 of this title as he determines such entity to be capable of meeting and performing. The number and type of such requirements and functions shall, during the period of conditional designation, be progressively increased as the entity conditionally designated becomes capable of added responsibility so that, by the end of such period, the agency may be considered for designation under subsection (c) of this section.

(3) Any agreement under which any entity is conditionally designated as a health systems agency may be terminated by such entity upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such entity.

(4) The Secretary may not enter into an agreement with any entity under paragraph (1) for conditional designation as a health systems agency for a health service area until—

(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 300*l*–1(b) of this title and will be qualified to perform the functions prescribed by section 300*l*–2 of this title;

(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been received from the applicant and approved by the Secretary; and

(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate, with respect to such designation.

In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by each entity which has developed a plan referred to in section 246(b) of this title for all or part of the health service area with respect to which the application was submitted, and each regional medical program established in such area under subchapter VII of this chapter.

(c) (1) The Secretary shall enter into an agreement with an entity for its designation as a health systems agency if, on the basis of an application under paragraph (2) (and, in the case of an entity conditionally designated, on the basis of its performance during a period of conditional designation under subsection (b) of this section as a health systems agency for a health service area), the Secretary determines that such entity is capable of fulfilling, in a satisfactory manner, the requirements and functions of a health systems agency. Any such agreement under this subsection with an entity may be renewed in accordance with paragraph (3), shall contain such provisions respecting the requirements of sections 300*l*–1(b) and 300*l*–2 of this title and such conditions designed to carry out the purpose of this subchapter, as the Secretary may prescribe, and shall be for a term of not to exceed twelve months; except that, prior to the expiration of such term, such agreement may be terminated—

(A) by the entity at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the entity as the Secretary may by regulation prescribe, if the Secretary determines that the entity is not complying with or effectively carrying out the provisions of such agreement.

(2) The Secretary may not enter into an agreement with any entity under paragraph (1) for designation as a health systems agency for a health service area unless the entity has submitted an application to the Secretary for designation as a health systems agency, and the Governor of each State in which the area is located has been consulted respecting such designation of such entity. Such an application shall contain assurances satisfactory to the Secretary that the applicant meets the requirements of section 300*l*–1(b) of this title and is qualified to perform or is performing the functions prescribed by section 300*l*–2 of this title. In considering such applications, the Secretary shall give priority

to an application which has been recommended for approval by (A) each entity which has developed a plan referred to in section 246(b) of this title for all or part of the health service area with respect to which the application was submitted, and (B) each regional medical program established in such area under subchapter VII of this chapter.

(3) An agreement under this subsection for the designation of a health systems agency may be renewed by the Secretary for a period not to exceed twelve months if upon review (as provided in section 300n–4 of this title) of the agency's operation and performance of its functions, he determines that it has fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 300*l*–2 of this title and continues to meet the requirements of section 300*l*–1(b) of this title.

(d) If a designation under subsection (b) or (c) of this section of a health systems agency for a health services area is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b) or (c) of this section (as the Secretary determines appropriate), enter into a designation agreement with another entity to be the health systems agency for such area.

§300*l*–5. *Planning grants*

(a) The Secretary shall make in each fiscal year a grant to each health systems agency with which there is in effect a designation agreement under subsection (b) or (c) of section 300*l*–4 of this title. A grant under this subsection shall be made on such conditions as the Secretary determines is appropriate, shall be used by a health systems agency for compensation of agency personnel, collection of data, planning, and the performance of the functions of the agency, and shall be available for obligation for a period not to exceed the period for which its designation agreement is entered into or renewed (as the case may be). A health systems agency may use funds under a grant under this subsection to make payments under contracts with other entities to assist the health systems agency in the performance of its functions; but it shall not use funds under such a grant to make payments under a grant or contract with another entity for the development or delivery of health services or resources.

(b)(1) The amount of any grant under subsection (a) of this section to a health systems agency designated under section 300*l*–4(b) of this title shall be determined by the Secretary. The amount of any grant under subsection (a) of this section to any health systems agency designated under section 300*l*–4(c) of this title shall be the lesser of—

(A) the product of $0.50 and the population of the health service area for which the agency is designated, or

(B) $3,750,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

(2)(A) If the application of a health systems agency for such a grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of subparagraph (B) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

(i) the amount determined under paragraph (1), and

(ii) the lesser of (I) the amount of such non-Federal funds with respect to which the assurances were made, or (II) the product of $0.25 and the population of the health service area for which the agency is designated.

(B) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) of this section which is computed on the basis of the formula prescribed by subparagraph (A) shall—

(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

(3) The amount of a grant under subsection (a) of this section to a health systems agency designated under section 300*l*–4(c) of this title may not be less than $175,000.

(c)(1) For the purpose of making payments pursuant to grants made under subsection (a) of this section, there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $90,000,000 for the fiscal year ending June 30, 1976, and $125,000,000 for the fiscal year ending June 30, 1977.

(2) Notwithstanding subsection (b) of this section, if the total of the grants to be made under this section to health systems agencies for any fiscal year exceeds the total of the amounts appropriated under paragraph (1) for that fiscal year, the amount of the grant for that fiscal year to each health systems agency shall be an amount which bears the same ratio to the amount determined for that agency for that fiscal year under subsection (b) of this section as the total of the amounts appropriated under paragraph (1) for that fiscal year bears to the total amount required to make grants to all health systems agencies in accordance with the applicable provision of subsection (b) of this section; except that the amount of any grant to a health systems agency for any fiscal year shall not be less than $175,000, unless the amount appropriated for that fiscal year under paragraph (1) is less than the amount required to make such a grant to each health systems agency.

§300m. *Designation of State health planning and development agencies*

(a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m–2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) of this section enter into, continue in effect, or renew such an agreement.

(b)(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this part referred to as the "State Agency") to administer the State administrative program prescribed by

section 300m–1 of this title and to carry out the State's health planning and development functions prescribed by section 300m–2 of this title. The Secretary may not enter into such an agreement with the Governor of a State unless—

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m–2 of this title, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 300m–3 of this title.

(2)(A) The agreement entered into with a Governor of a State under subsection (a) of this section may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m–2 of this title. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

(B) The period of an agreement described in subparagraph (A) may not exceed twenty-four months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 300m–2 of this title as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3).

(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety days' notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed twelve months, except that, prior to the expiration of such term, such agreement may be terminated—

(A) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines

that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement.

An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed twelve months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the applicable State administrative program continues to meet the requirements of section 300m–1 of this title.

(c) If a designation agreement with the Governor of a State entered into under subsection (b)(2) or (b)(3) of this section is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

(d) If, upon the expiration of the fourth fiscal year which begins after 1975, an agreement under this section for the designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this chapter, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect.

§300m–1. *State administrative program*

(a) A State administrative program (hereinafter in this section referred to as the "State Program") is a program for the performance within the State by its State Agency of the functions prescribed by section 300m–2 of this title. The Secretary may not approve a State Program for a State unless it—

(1) meets the requirements of subsection (b) of this section;

(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

(b) The State Program of a State must—

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 300m–2 of this title and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

(3) provide for adequate consultation with and authority for, the Statewide Health Coordinating Council (prescribed by section 300m–3 of this title), in carrying out such functions and the State Program;

(4)(A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe;

(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 4728(a) of this title, but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(5) require the State Agency to perform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 300n–1 of this title;

(6) require the State Agency to (A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

(7)(A) provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 242k(e) of this title of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

(10) require the State Agency to make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this subchapter;

(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this subchapter; and

(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 300m–2(a) of this title or under subchapter XIV of this chapter which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 300*l*–2 of this title by a health systems agency within the State—

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

(B) the decision of the reviewing agency shall for purposes of this subchapter and subchapter XIV of this chapter be considered the decision of the State health planning and development agency.

(c) The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b) of this section. The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year.

§300m–2. *State health planning and development functions*

(a) Each State Agency of a State designated under section 300m(b)(3) of this title shall, except as authorized under subsection (b) of this section, perform within the State the following functions:

(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 300m–3 (c)(2) of this title) and the plans of the health systems agencies within the State which relate to the government of the State.

(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 300m–3(c) of this title.

(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 300*o*–2 of this title, and in the performance of its functions generally.

(4) (A) Serve as the designated planning agency of the State for the purposes of section 1320a–1 of this title if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be

offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 300*l*–2(f) of this title.

(5) After consideration of recommendations submitted by health systems agencies under section 300*l*–2(f) of this title respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health systems agencies under section 300*l*–2(g) of this title respecting the appropriateness of such services, make public its findings.

(b) (1) Any function described in subsection (a) of this section may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) of this section shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after January 4, 1975.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 300*l*–2(g) of this title with respect to the appropriateness of the service.

(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6), or (7) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

§300m–3. *Statewide Health Coordinating Council*

(a) A State health planning and development agency designated under section 300*m* of this title shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the "SHCC") which (1) is organized in the manner described by subsection (b) of this section, and (2) performs the functions listed in subsection (c) of this section.

(b)(1) A SHCC of a State shall be composed in the following manner:

(A)(i) A SHCC shall have no fewer than sixteen representatives appointed by the Governor of the State from lists of at least five nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State.

(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC.

(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.

(B) In addition to the appointments made under subparagraph (A), the Governor of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

(C) Not less than one-third of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 300n(3) of this title).

(D) Where two or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities.

(2) The SHCC shall select from among its members a chairman.

(3) The SHCC shall conduct all of its business meetings in public, and shall meet at least once in each calendar quarter of a year.

(c) A SHCC shall perform the following functions:

(1) Review annually and coordinate the HSP and AIP of each health systems agency within the State and report to the Secretary, for purposes of his review under section 300n–4(c) of this title, its comments on such HSP and AIP.

(2)(A) Prepare and review and revise as necessary (but at least annually) a State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for each year for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with the HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs.

(B) In the preparation and revision of the State health plan, the SHCC shall review and consider the preliminary State health plan submitted by the State agency under section 300m–2(a)(2) of this title, and shall conduct a public hearing on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to any such hearing, the SHCC shall publish in at least two newspapers of general circulation in the State a notice of its consideration of the proposed plan, the time and place of the hearing, the place at which interested persons may consult the plan in advance of the hearing, and the place and period during which to direct written comment to the SHCC on the plan.

(3) Review annually the budget of each such health systems agency and report to the Secretary, for purposes of his review under section 300n–4(a) of this title, its comments on such budget.

(4) Review applications submitted by such health systems agencies for grants under sections 300*l*–5 and 300t of this title and report to the Secretary its comments on such applications.

(5) Advise the State Agency of the State generally on the performance of its functions.

(6) Review annually and approve or disapprove any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this chapter, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this chapter or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. If a SHCC disapproved such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State which submitted such plan or application or another agency of such State, a review of the SHCC decision. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

§300m–4. *Grants for State health planning and development*

(a) The Secretary shall make grants to State health planning and development agencies designated under subsection (b)(2) or (b)(3) of section 300m of this title to assist them in meeting the costs of their operation. Any grant made under this subsection to a State Agency shall be available for obligation only for a period not to exceed the period for which its designation agreement is entered into or renewed. The amount of any grant made under this subsection shall be determined by the Secretary, except that no grant to a designated State Agency may exceed 75 per centum of its operation costs (as determined under regulations of the Secretary) during the period for which the grant is available for obligation.

(b) Grants under subsection (a) of this section shall be made on such terms and conditions as the Secretary may prescribe; except that the Secretary may not make a grant to a State Agency unless he receives satisfactory assurances that the State Agency will expend in performing the functions prescribed by section 300m–2 of this title during the fiscal year for which the grant is sought an amount of funds from non-Federal sources which is at least as great as the average amount of funds expended, in the three years immediately preceding the fiscal year for which such grant is sought, by the State, for which such State Agency has been designated, for the purposes for which funds under such grant may be used (excluding expenditures of a nonrecurring nature).

(c) For the purpose of making payments under grants under subsection (a) of this section, there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, and $35,000,000 for the fiscal year ending June 30, 1977.

§300m–5. *Grants for rate regulation—Limitation*

(a) For the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care, the Secretary may make to

a State Agency designated, under an agreement entered into under section 300m(b)(3) of this title, for a State which (in accordance with regulations prescribed by the Secretary) has indicated an intent to regulate (not later than six months after January 4, 1975) rates for the provision of health care within the State. Not more than six State Agencies may receive grants under this subsection.

(b) (1) A State Agency which receives a grant under subsection (a) of this section shall—

(A) provide the Secretary satisfactory evidence that the State Agency has under State law the authority to carry out rate regulation functions in accordance with this section and provide the Secretary a current budget for the performance of such functions by it;

(B) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibility in the performance of such functions, and shall have a professional staff for rate regulation, which staff shall be headed by a Director;

(C) provide for such methods of administration as found by the Secretary to be necessary for the proper and efficient administration of such functions;

(D) perform its functions in accordance with procedures established and published by it, which procedures shall conform to the requirements of section 300n–1 of this title;

(E) comply with the requirements prescribed by paragraphs (6) through (12) of section 300m–1(b) of this title with respect to the functions prescribed by subsection (a) of this section;

(F) provide for the establishment of a procedure under which the State Agency will obtain the recommendation of the appropriate health systems agency prior to conducting a review of the rates charged or proposed to be charged for services; and

(G) meet such other requirements as the Secretary may prescribe.

(2) In prescribing requirements under paragraph (1) of this subsection, the Secretary shall consider the manner in which a State Agency shall perform its functions under a grant under subsection (a) of this section, including whether the State Agency should—

(A) permit those engaged in the delivery of health services to retain savings accruing to them from effective management and cost control,

(B) create incentives at each point in the delivery of health services for utilization of the most economical modes of services feasible,

(C) document the need for and cost implications of each new service for which a determination of reimbursement rates is sought, and

(D) employ for each type or class of person engaged in the delivery of health services—

(i) a unit for determining the reimbursement rates, and

(ii) a base for determining rates of change in the reimbursement rates,

which unit and base are satisfactory to the Secretary.

(c) Grants under subsection (a) of this section shall be made on such terms and conditions as the Secretary may prescribe, except that (1) such a grant shall be available for obligation only during the one-year period beginning on the date such grant was made, and (2) no State Agency may receive more than three grants under subsection (a) of this section.

(d) Each State Agency which receives a grant under subsection (a) of this section shall report to the Secretary (in such form and manner as he shall prescribe) on the effectiveness of the rate regulation program assisted by such grant. The Secretary shall report annually to the Congress on the effectiveness of the programs assisted by the grants authorized by subsection (a) of this section.

(e) There are authorized to be appropriated to make payments under grants under subsection (a) of this section, $4,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976, and $6,000,000 for the fiscal year ending June 30, 1977.

§300n. *Definitions*

For purposes of this subchapter:

(1) The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico.

(2) The term "Governor" means the chief executive officer of a State or his designee.

(3) The term "provider of health care" means an individual—

(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, optometrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, substance abuse treatment facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

(B) who is an indirect provider of health care in that the individual—

(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care.

(II) Entities engaged in the provision of health care or in such research or instruction.

(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

(IV) Entities engaged in producing drugs or such other articles.

(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

"(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(4) The term "health resources" includes health services, health professions personnel, and health facilities, except that such term does not include Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(5) The term "institutional health services" means the health services provided through health care facilities and health maintenance organizations (as such facilities and organizations are defined in regulations prescribed under section 1320a–1 of this title) and includes the entities through which such services are provided.

§300n–1. *Procedures and criteria for review of proposed health system changes*

(a) In conducting reviews pursuant to subsections (e), (f), and (g) of section 300*l*–2 of the title or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; and in performing its review functions under section 300m–2 of this title, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by health systems agencies and States Agencies may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) of this section at least the following:

(1) Written notification to affected persons of the beginning of a review.

(2) Schedules for reviews which provide that no review shall, to the extent practicable, take longer than ninety days from the date the notification described in paragraph (1) is made.

(3) Provision for persons subject to a review to submit to the agency or State Agency (in such form and manner as the agency or State Agency shall prescribe and publish) such information as the agency or State Agency may require concerning the subject of such review.

(4) Submission of applications (subject to review by a health systems agency or a State Agency) made under this chapter or other provisions of law for Federal financial assistance for health services to the health systems agency or State Agency at such time and in such manner as it may require.

(5) Submission of periodic reports by providers of health services and other persons subject to agency or State Agency review respecting the development of proposals subject to review.

(6) Provision for written findings which state the basis for any final decision or recommendation made by the agency or State Agency.

(7) Notification of providers of health services and other persons subject to agency or State Agency review of the status of the agency or State Agency review of the health services or proposals subject to review,

findings made in the course of such review, and other appropriate information respecting such review.

(8) Provision for public hearings in the course of agency or State Agency review if requested by persons directly affected by the review; and provision for public hearings, for good cause shown, respecting agency and State Agency decisions.

(9) Preparation and publication of regular reports by the agency and State Agency of the reviews being conducted (including a statement concerning the status of each such review) and of the reviews completed by the agency and State Agency (including a general statement of the findings and decisions made in the course of such reviews) since the publication of the last such report.

(10) Access by the general public to all applications reviewed by the agency and State Agency and to all other written materials pertinent to any agency or State Agency review.

(11) In the case of construction projects, submission to the agency and State Agency by the entities proposing the projects of letters of intent in such detail as may be necessary to inform the agency and State Agency of the scope and nature of the projects at the earliest possible opportunity in the course of planning of such construction projects.

(c) Criteria required by subsection (a) of this section for health systems agency and State Agency review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable HSP and AIP.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of alternatives, less costly, or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

(6) In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

(8) The special needs and circumstances of health maintenance organizations for which assistance may be provided under subchapter XI of this chapter.

(9) In the case of a construction project—

(A) the costs and methods of the proposed construction, and

(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

The criteria established by any health systems agency or State Agency under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 300e–5(c) of this title.

§300n–2. *Technical assistance*

(a) The Secretary shall provide (directly or through grants or contracts, or both) to designated health systems agencies and State Agencies (1) assistance in developing their health plans and approaches to planning various types of health services, (2) technical materials, including methodologies, policies, and standards appropriate for use in health planning, and (3) other technical assistance as may be necessary in order that such agencies may properly perform their functions.

(b) The Secretary shall include in the materials provided under subsection (a) of this section the following:

(1)(A) Specification of the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status.

(B) Specification of the minimum data needed to determine the status of the health resources and services of a health service area.

(C) Specification of the minimum data needed to describe the use of health resources and services within a health service area.

(2) Planning approaches, methodologies, policies, and standards which shall be consistent with the guidelines established by the Secretary under section 300k–1 of this title for appropriate planning and development of health resources, and which shall cover the priorities listed in section 300k–2 of this title.

(3) Guidelines for the organization and operation of health systems agencies and State Agencies including guidelines for—

(A) the structure of a health systems agency, consistent with section 300*l*–1(b) of this title, and of a State Agency, consistent with section 300m–1 of this title;

(B) the conduct of the planning and development processes;

(C) the performance of health systems agency functions in accordance with section 300*l*–2 of this title; and

(D) the performance of State Agency functions in accordance with section 300m–2 of this title.

(c) In order to facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology, the Secretary shall establish a national health planning information center to support the health planning and resources development programs of health systems agencies, State Agencies, and other entities concerned with health planning and resources development; to provide access to current information on health planning and resources development; and to provide information for use in the analysis of issues and problems related to health planning and resources development.

(d) The Secretary shall establish the following within one year of January 4, 1975:

(1) A uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health services institutions as defined by the Secretary in regulations. Such system shall provide for the calculation of the aggregate volume to be based on:

(A) The number of patient days;

(B) The number of patient admissions;

(C) The number of out-patient visits; and

(D) Other relevant factors as determined by the Secretary.

(2) A uniform system for cost accounting and calculating the volume of services provided by health services institutions. Such system shall:

(A) Include the establishment of specific cost centers and, where appropriate, subcost centers.

(B) Include the designation of an appropriate volume factor for each cost center.

(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions), and different sizes of such types of institutions.

(3) A uniform system for calculating rates to be charged to health insurers and other health institutions payors by health service institutions. Such system shall:

(A) Be based on an all-inclusive rate for various categories of patients (including, but not limited to individuals receiving medical, surgical, pediatric, obstetric, and psychiatric institutional health services).

(B) Provide that such rates reflect the true cost of providing services to each such category of patients. The system shall provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category.

(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health service institutions) and different sizes of such types of institutions.

(D) Provide that differences in rates to various classes of purchasers (including health insurers, direct service payors, and other health institution payors) be based on justified and documented differences in the costs of operation of health service institutions made possible by the actions of such purchasers.

(4) A classification system for health services institutions. Such classification system shall quantitatively describe and group health services institutions of the various types. Factors included in such classification system shall include—

(A) the number of beds operated by an institution;

(B) the geographic location of an institution;

(C) the operation of a postgraduate physician training program by an institution; and

(D) the complexity of services provided by an institution.

(5) A uniform system for the reporting by health services institutions of—

(A) the aggregate cost of operation and the aggregate volume of services, as calculated in accordance with the system established by the Secretary under paragraph (1);

(B) the costs and volume of services at various cost centers, and subcost centers, as calculated in accordance with the system established by the Secretary under paragraph (2); and

(C) rates, by category of patient and class of purchaser, as calculated in accordance with the system established by the Secretary under paragraph (3).

Such system shall provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions) and different sizes of such institutions.

§300n–3. *Centers for health planning*

(a) For the purposes of assisting the Secretary in carrying out this subchapter, providing such technical and consulting assistance as health systems agencies and State Agencies may from time to time require, conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies, and standards, the Secretary shall by grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance. To the extent practicable, the Secretary shall provide assistance under this section so that at least five such centers will be in operation by June 30, 1976.

(b)(1) No grant or contract may be made under this section for planning or developing a center unless the Secretary determines that when it is operational it will meet the requirements listed in paragraph (2) and no grant or contract may be made under this section for operation of a center unless the center meets such requirements.

(2) The requirements referred to in paragraph (1) are as follows:

(A) There shall be a full-time director of the center who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of health planning and resources development, and there shall be such additional professional staff as may be appropriate.

(B) The staff of the center shall represent a diversity of relevant disciplines.

(C) Such additional requirements as the Secretary may by regulation prescribe.

(c) Centers assisted under this section (1) may enter into arrangements with health systems agencies and State Agencies for the provision of such services as may be appropriate and necessary in assisting the agencies and State Agencies in performing their functions under section 300*l*–2 or 300m–2 of this title, respectively, and (2) shall use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies such planning approaches, methodologies,' policies and standards as they develop.

(d) For the purpose of making payments pursuant to grants and contracts under subsection (a) of this section there are authorized to be appropriated

$5,000,000 for the fiscal year ending June 30, 1975, $8,000,000 for the fiscal year ending June 30, 1976, and $10,000,000 for the fiscal year ending June 30, 1977.

§300n–4. *Review by the Secretary*

(a) The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval the Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 300m–3(c)(3) of this title. Information submitted to the Secretary by a health systems agency or a State Agency in connection with the Secretary's review under this subsection shall be made available by the Secretary, upon request, to the appropriate committees (and their subcommittees) of the Congress.

(b) The Secretary shall prescribe performance standards covering the structure, operation, and performance of the functions of each designated health systems agency and State Agency, and he shall establish a reporting system based on the performance standards that allows for continuous review of the structure, operation, and performance of the functions of such agencies.

(c) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated health systems agency to determine—

(1) the adequacy of the HSP of the agency for meeting the needs of the residents of the area for a healthful environment and for accessible, acceptable and continuous quality health care at reasonable costs, and the effectiveness of the AIP in achieving the system described in the HSP;

(2) if the structure, operation, and performance of the functions of the agency meet the requirements of sections 300*l*–1 (b) and 300*l*–2 of this title;

(3) the extent to which the agency's governing body (and executive committee (if any)) represents the residents of the health service area for which the agency is designated;

(4) the professional credentials and competence of the staff of the agency;

(5) the appropriateness of the data assembled pursuant to section 300*l*–2 (b) (1) of this title and the quality of the analyses of such data;

(6) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and the AIP; and

(7) the extent to which it may be demonstrated that—

(A) the health of the residents in the agency's health service area has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in such area has been improved; and

(C) increases in costs of the provision of health care have been restrained.

(d) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated State Agency to determine—

(1) the adequacy of the State health plan of the Statewide Health Coordinating Council prepared under section 300m–3(c)(2) of this title in

meeting the needs of the residents of the State for a healthful environment and for accessible, acceptable, and continuous quality health care at reasonable costs;

(2) if the structure, operation, and performance of the functions of the State Agency meet the requirements of sections 300m–1 and 300m–2 of this title;

(3) the extent to which the Statewide Health Coordinating Council has a membership meeting, and has performed in a manner consistent with the requirements of section 300m–3 of this title;

(4) the professional credentials and competence of the staff of the State Agency;

(5) the extent to which financial assistance provided under subchapter XIV of this chapter by the State Agency has been used in an effective manner to achieve the State's health plan under section 300m–3 (c) (2) of this title, and

(6) the extent to which it may be demonstrated that—

(A) the health of the residents of the State has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in the State has been improved; and

(C) increases in costs of the provision of health care have been restrained.

§300n–5. *Special provisions for certain states and territories*

(a) Any State which—

(1) has no county or municipal public health institution or department, and

(2) has, prior to January 4, 1975, maintained a health planning system which substantially complies with the purposes of this subchapter.

§300o–1. *Promulgation of regulations*

The Secretary shall by regulation—

(1) prescribe the general manner in which the State Agency of each State shall determine for the State medical facilities plan under section 300o–2 of this title the priority among projects within the State for which assistance is available under this subchapter, based on the relative need of different areas within the State for such projects and giving special consideration—

(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid non-compliance with State or voluntary licensure or accreditation standards, and

(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

(2) prescribe for medical facilities projects assisted under this subchapter general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

(3) prescribe criteria for determining needs for medical facility beds and needs for medical facilities, and for developing plans for the distribution of such beds and facilities;

(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

(5) require each State medical facilities plan under section 300k–3 of this title to provide for adequate medical facilities for all persons residing in the State and adequate facilities to furnish needed health services for persons unable to pay therefor; and

(6) prescribe the general manner in which each entity which receives financial assistance under this subchapter or has received financial assistance under this subchapter or subchapter IV of this chapter shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

§300o–2. *State medical facilities plan*

(a) Before an application for assistance under this subchapter (other than part D) for a medical facility project described in section 300o of this title may be approved, the State Agency of the State in which such project is located must have submitted to the Secretary and had approved by him a State medical facilities plan. To be approved by the Secretary a State medical facilities plan for a State must—

(1) prescribe that the State Agency of the State shall administer or supervise the administration of the plan and contain evidence satisfactory to the Secretary that the State Agency has the authority to carry out the plan in conformity with this subchapter;

(2) prescribe that the Statewide Health Coordinating Council of the State shall advise and consult with the State Agency in carrying out the plan;

(3) be approved by the Statewide Health Coordinating Council as consistent with the State health plan developed pursuant to section 300m–3(c)(2) of this title;

(4) set forth, in accordance with criteria established in regulations prescribed under section 300*o*–1(a) of this title and on the basis of a statewide inventory of existing medical facilities, a survey of need, and the plans of health systems agencies within the State—

(A) the number and type of medical facility beds and medical facilities needed to provide adequate inpatient care to people residing in the State, and a plan for the distribution of such beds and facilities in health services areas throughout the State,

(B) the number and type of outpatient and other medical facilities needed to provide adequate public health services and outpatient care to people residing in the State, and a plan for the distribution of such facilities in health service areas throughout the State, and

(C) the extent to which existing medical facilities in the State are in need of modernization or conversion to new uses;

(5) set forth a program for the State for assistance under this subchapter for projects described in section 300*o*, of this title which program shall indicate the type of assistance which should be made available to each project and shall conform to the assessment of need set forth pursuant to paragraph (4) and regulations promulgated under section 300*o*–1(a) of this title;

(6) set forth (in accordance with regulations promulgated under section 300*o*–1(a) of this title) priorities for the provision of assistance under this subchapter for projects in the program set forth pursuant to paragraph (4);

(7) provide minimum requirements (to be fixed in the discretion of the State Agency) for the maintenance and operation of facilities which receive assistance under this subchapter, and provide for enforcement of such standards;

(8) provide for affording to every applicant for assistance for a medical facilities project under this subchapter an opportunity for a hearing before the State Agency; and

(9) provide that the State Agency will from time to time, but not less often than annually, review the plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State medical facilities plan and any modification thereof which complies with the provisions of subsection (a) of this section if the State Agency, as determined under the review made under section 300n–4(d) of this title, is organized and operated in the manner prescribed by section 300m–1 of this title and is carrying out its functions under section 300m–2 of this title in a manner satisfactory to the Secretary. If any such plan or modification thereof shall have been disapproved by the Secretary for failure to comply with subsection (a) of this section, the Secretary shall, upon request of the State Agency, afford it an opportunity for hearing.

APPENDIX D

Among the programs subject to termination pursuant to 42 U.S.C. §300m(d) if a state fails to comply with the requirements of the Health Planning Act are the following grants and other forms of funding under the Public Health Service Act, 42 U.S.C. §201 *et seq.*:

(1) Grants for the development of improved methods for the care, treatment, and rehabilitation of the mentally ill, and for the establishment and maintenance of traineeships in the field of mental health. 42 U.S.C. §242a.

(2) Grants to cover the cost of traineeships for graduate or specialized training in public health for physicians, engineers, nurses, sanitarians, and other professional health personnel. 42 U.S.C. §244–1.

(3) Grants for graduate public health training. 42 U.S.C. §245a.

(4) Grants for comprehensive public health services. 42 U.S.C. §246.

(5) Grants for communicable and other disease control programs. 42 U.S.C. §247b.

(6) Grants for venereal disease prevention and control programs. 42 U.S.C. §247b.

(7) Grants to establish and operate family health service clinics for domestic agricultural migrants. 42 U.S.C. §247d.

(8) Grants for the planning and development of community health centers. 42 U.S.C. §254c.

(9) Establishment of a regional branch of the National Library of Medicine. 42 U.S.C. §280a–1.

(10) Grants for training in medical library sciences, special medical library projects, and establishing, expanding, and improving medical libraries and related resources and establishment of regional medical libraries. 42 U.S.C. §§2806–4, 5, 7, 8.

(11) Grants and contractual agreements to support National Cancer Research and Demonstration Centers, and Cancer Control Programs. 42 U.S.C. §§286b, 286c.

(12) Grants for the establishment of prevention and control programs, research and demonstration centers, and research and training in diseases of the heart, blood vessels, lung and blood. 42 U.S.C. §§287a, 287c, 287d.

(13) Grants for the establishment of clinical traineeships in dental medicine. 42 U.S.C. §288a.

(14) Grants for research and training in the diagnosis, prevention, and treatment of diabetes and metabolic and digestive diseases. 42 U.S.C. §289c–1.

(15) Grants to establish research and training centers in the areas of diabetes and metabolic digestive diseases. 42 U.S.C. §289c–2.

(16) Grants for the establishment of arthritis screening, detection, and prevention programs, and the construction and operation of comprehensive arthritis centers. 42 U.S.C. §§289c–5, 6.

(17) Support in the development of comprehensive health, education, training, research, and planning programs for the prevention and treatment of mental illness and for the rehabilitation of the mentally ill. 42 U.S.C. §289k–1.

(18) Grants for biomedical and behavioral research in matters relating to the cause, diagnosis, prevention, and treatment of the diseases which concern the National Institute of Health and the Alcohol, Drug Abuse, and Mental Health Administration. 42 U.S.C. §289l–1.

(19) Grants for the establishment of specialized burn treatment centers. 42 U.S.C. §290a.

(20) Grants, loans, and loan guarantees for the construction and modernization of hospitals and other medical facilities. 42 U.S.C. §§291b, 291j–1.

(21) Grants for the construction or modernization of hospital emergency rooms. 42 U.S.C. §291j–9.

(22) Loan for the construction of experimental or demonstration hospital facilities. 42 U.S.C. §291m–1.

(23) Grants for the construction of health research facilities. 42 U.S.C. §292d.

(24) Grants and loan guarantees for the construction of teaching facilities for medical, dental, and other health personnel. 42 U.S.C. §§293a, 293i.

(25) Loan agreements for the establishment of student loan funds. 42 U.S.C. §294.

(26) Grants for the construction of facilities for research in the field of mental retardation. 42 U.S.C. §295a.

(27) Grants for traineeships in family medicine, and for the support of postgraduate training programs for physicians, dentists, and health professions teaching personnel. 42 U.S.C. §§295d–1, 295e–1, 2, 3.

(28) Capitation grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy and podiatry. 42 U.S.C. §294f.

(29) Start-up grants to new schools of medicine, osteopathy, or dentistry. 42 U.S.C. §295f–1.

(30) Special project grants and contracts to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry. 42 U.S.C. §295f–2.

(31) Grants to assist schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry. 42 U.S.C. §295f–3.

(32) Grants to improve the distribution of health manpower. 42 U.S.C. §295f–4.

(33) Grants and contracts to provide training programs in emergency medical services. 42 U.S.C. §295f–6.

(34) Grants for construction and improvement of teaching facilities and training centers for allied health professions personnel. 42 U.S.C. §§295h, 295h–1, 2.

(35) Grants for scholarships and work-study programs, and loans for students of allied health professions. 42 U.S.C. §§295h–3b, 3c, 3d.

(36) Grants and loans guarantees for construction of new facilities and expansion of existing facilities for schools of nursing. 42 U.S.C. §§296a, 296d.

(37) Grants for establishment of nurse training programs, special project grants, and financial distress grants to schools of nursing. 42 U.S.C. §§296a, 296d, 296j, 296l, 296m.

(38) Capitation grants to schools of nursing. 42 U.S.C. §296e.

(39) Grants for scholarships, traineeships, and student loans for nursing students. 42 U.S.C. §§297, 297a, 297f, 297j.

(40) Grants and contracts to schools of nursing to encourage full utilization of educational talent. 42 U.S.C. §298c–7.

(41) Grants for planning, establishing, and operating regional medical programs and health services delivery programs. 42 U.S.C. §§299c, 299d, 299j.

(42) Grants and contracts for projects, training, and research relating to family planning programs. 42 U.S.C. §300, 300a–1, 2.

(43) Grants and contracts for projects for research and development of programs for diagnosis, control, and treatment of sickle cell anemia. 42 U.S.C. §300b–1.

(44) Grants for the development, establishment and expansion of comprehensive hemophilia diagnostic and treatment centers and blood separation centers. 42 U.S.C. §§300c–21, 22.

(45) Grants and contracts for establishment, operation, expansion, and improvement of emergency medical services systems. 42 U.S.C. §§300d–2, 3.

(46) Grants, contracts, loans, and loan guarantees for planning, development, and initial operation of Health Maintenance Organizations. 42 U.S.C. §§300e–3, 4.

(47) Grants, loans, and loan guarantees for construction, modernization, and conversion of medical facilities. 42 U.S.C. §§300p, 300q, 300s.